| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445516 | A. BUILDING **01 - MAIN BUILDING**<br>B. WING _____ | R<br>**08/10/2018** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CREEKSIDE HEALTH AND REHABILITATION CENTER** | **306 W DUE WEST AVE**<br>**MADISON, TN 37115** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {K 000} | INITIAL COMMENTS<br><br>A Life Safety Code Survey revisit was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 07/02/2018 for all previously cited deficiencies on 05/14/2018. During this Life Safety Survey revisit, Creekside Health and Rehab was found in substantial compliance with the requirements of the Rules of Tennessee Department of Health Board for Licensing Health Care Facilities Chapter 1200-08-6 Standards for Nursing Homes and National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition). | {K 000} | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445516 | A. BUILDING _____ B. WING _____ | R 08/10/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREEKSIDE HEALTH AND REHABILITATION CENTER | 306 W DUE WEST AVE MADISON, TN 37115 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {E 000} | Initial Comments<br><br>During the emergency preparedness portion of the life safety survey on 05/14/2018, no deficiencies were cited under emergency preparedness. | {E 000} | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVE
OMB NO 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445516 | A. BUILDING 01 - MAIN BUILDING<br>B. WING | 05/14/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREEKSIDE HEALTH AND REHABILITATION CENTER | 306 W DUE WEST AVE<br>MADISON, TN 37115 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulations Office of Health Care Facilities on 05/14/2018. During this Life Safety Survey, Creekside Health and Rehab was found not in substantial compliance with the requirements of the Rules of Tennessee Department of Health Board for Licensing Health Care Facilities Chapter 1200-08-6 Standards for Nursing Homes and National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition).<br><br>* All penetrations requiring Fire Stop shall be repaired in accordance with a tested and approved Fire Stop System meeting the requirements of the UL (Underwriters Laboratory) assembly to which the Fire Stop is being applied. The system used shall be recorded and documentation shall be maintained for the life of the installation.<br><br>* All damaged, painted, or corroded sprinklers shall be replaced in accordance with NFPA 25, Standards for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition). | K 000 | K321<br><br>Door closers were installed on room 216 and 219 on 5/31/18.<br><br>2. A 100% audit of the building was performed on 5/14/18 by the Maintenance Director to ensure all other areas requiring automatic closing devises were present as required.<br><br>3. A monthly check of all doors requiring self or automatic closing devises will be completed weekly by the Maintenance Director for a period of (1) month then monthly for (2) additional months June – August 2018 to ensure compliance with F321.<br>The Maintenance Director Was in-serviced on the Requirements noted on the 2567 on 5/28/18. | 5/28/18 |
| K 321<br>SS=D | Hazardous Areas - Enclosure<br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be | K 321 | 4. The results of the weekly & monthly audits will be presented in the monthly Quality Assurance meeting to assure compliance with the requirements of F321. June – August 2018.<br>The Quality Assurance Performance Improvement Committee will include but not be limited to the following: | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: NHA | (X6) DATE: 6/4/18

Any deficiency statement ending with an asterisk(*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



Received 6-4-18

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445516 | A. BUILDING 01 - MAIN BUILDING<br>B. WING | 05/14/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREEKSIDE HEALTH AND REHABILITATION CENTER | 306 W DUE WEST AVE<br>MADISON, TN 37115 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 321 | Continued From page 1<br>separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9 | K 321 | Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Services Director, Dietary Manager, Housekeeping & Laundry Director, and Maintenance Director. | |

Area Automatic Sprinkler
Separation N/A
a. Boiler and Fuel-Fired Heater Rooms
b. Laundries (larger than 100 square feet)
c. Repair, Maintenance, and Paint Shops
d. Soiled Linen Rooms (exceeding 64 gallons)
e. Trash Collection Rooms
(exceeding 64 gallons)
f. Combustible Storage Rooms/Spaces
(over 50 square feet)
g. Laboratories (if classified as Severe Hazard - see K322)
This REQUIREMENT is not met as evidenced by:
Based on observations, the facility failed to maintain hazardous areas.

The findings included:

Observations on 05/14/20188 between 10:50 AM - 10:53 AM, revealed the following medical records storage area doors were not equipped with self-closers:
a. Room 216
b. Room 219
NFPA 101, 19.3.2.1.3 (2012 Edition)

The maintenance assistant was present when these deficiencies were identified, and were later

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445516 | A. BUILDING 01 - MAIN BUILDING<br>B. WING | 05/14/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREEKSIDE HEALTH AND REHABILITATION CENTER | 306 W DUE WEST AVE<br>MADISON, TN 37115 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 321 | Continued From page 2<br>acknowledged by the administrator during the exit conference on 05/14/2018. | K 321 | K353<br>1. The sprinkler head noted in room 19 has been cleaned to remove dust and paint. | 5/28/18 |
| K 353 SS=D | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>b) Who provided system test<br>c) Water system supply source<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, the facility failed to maintain the sprinkler system.<br><br>The finding included:<br><br>Observation on 05/14/2018 at 10:08 AM, revealed a painted sprinkler in first closet of room 19.<br>NFPA 101, 19.3.5.1 (2012 Edition), NFPA 101, 9.7.5 (2012 Edition), NFPA 25, 5.2.1.1.1 (2011 Edition) NFPA 25, 5.2.1.1.2 (2011 Edition)<br><br>The maintenance assistant was present when the | K 353 | 2. A 100% inspection of all sprinkler heads was performed by the Maintenance Director to ensure all sprinkler heads meet the requirements of K353 from 5/14/18 through 5/18/18.<br><br>3. A monthly check of all sprinkler heads will be performed weekly by the Maintenance Director for (1) month then monthly for (2) additional months June – August 2018 to ensure compliance with K353.<br>The Maintenance Director was in-serviced on the requirements noted on the 2567 on 5/28/18.<br><br>4. The results of the weekly & monthly audits will be presented in the monthly Quality Assurance meeting to assure compliance with the requirements of K353. June – August 2018.<br>The Quality Assurance Performance Improvement Committee will include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Services Director, Dietary Manager, Housekeeping & Laundry Director, and Maintenance Director. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445516 | A. BUILDING 01 - MAIN BUILDING<br>B. WING | 05/14/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREEKSIDE HEALTH AND REHABILITATION CENTER | 306 W DUE WEST AVE<br>MADISON, TN 37115 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 353 | Continued From page 3<br>deficiency was identified, and was later acknowledged by the administrator during the exit conference on 05/14/2018. | K 353 | K919<br>1. The electrical cord located in the media room was replaced on 5/14/18.<br>2. A 100% audit of the building was performed from 5/14/18 through 5/18/18 to ensure no additional power cords were improperly modified.<br>3. A monthly check of the building will be performed weekly by the Maintenance Director for (1) month then monthly for (2) additional months June – August 2018 to ensure compliance with K919.<br>The Maintenance Director was in-serviced on the requirements noted on the 2567 on 5/28/18.<br>4. The results of the weekly & monthly audits will be presented in the monthly Quality Assurance meeting to assure compliance with the requirements of K919, June – August 2018.<br>The Quality Assurance Performance Improvement Committee will include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Services Director, Dietary Manager, Housekeeping & Laundry Director, and Maintenance Director. | 5/28/18 |
| K 919<br>SS=D | Electrical Equipment - Other<br>CFR(s): NFPA 101<br><br>Electrical Equipment - Other<br>List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.<br>Chapter 10 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, the facility failed to maintain electrical equipment.<br><br>The finding included:<br><br>1. Observation on 05/14/2018 at 10:32 AM, revealed a modified electrical cord (spliced and electrical taped) on the sump pump in the media room.<br>NFPA 101, 19.5.1.1 (2012 Edition), NFPA 101, 9.1.2 (2012 Edition), NFPA 70, 110.12 (2011 Edition)<br><br>The maintenance assistant was present when the deficiency was identified, and was later acknowledged by the administrator during the exit conference on 05/14/2018. | K 919 | | |
| K 920<br>SS=D | Electrical Equipment - Power Cords and Extens<br>CFR(s): NFPA 101<br><br>Electrical Equipment - Power Cords and Extension Cords | K 920 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445516 | A. BUILDING 01 - MAIN BUILDING<br>B. WING _____ | 05/14/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREEKSIDE HEALTH AND REHABILITATION CENTER | 306 W DUE WEST AVE<br>MADISON, TN 37115 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 920 | Continued From page 4<br>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.<br>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, the facility failed to maintain electrical equipment.<br><br>The findings included:<br><br>1. Observations on 05/14/2018 between 9:38 AM - 10:35 AM, revealed personal equipment plugged into medical grade power strips in the following locations:<br>a. Room 37<br>b. Room 112<br>NFPA 99, 10.2.3.6 (2012 Edition)<br><br>2. Observations on 05/14/2018 between 10:10 AM - 10:20 AM, revealed extension cords in the | K 920 | K920<br><br>1. The personal equipment plugged Into medical grade power strips in Room 37 & 112 were unplugged From the medical grade power strips and plugged into UL 1363 grade power strips on 5/14/18.<br><br>The extension cords located in Room 20 and Room 5 were removed on 5/14/18.<br><br>The unapproved power strips located in Room 3 and Room 217 were removed on 5/14/18.<br><br>2. A 100% audit of the building was performed from 5/14/18 through 5/18/18 to ensure no additional personal equipment was plugged into a medical grade power strip, no extension cords were present, and no unapproved power strips were located in the building.<br><br>3. A monthly check of the building will be performed weekly by the Maintenance Director for (1) month then monthly for (2) additional months June – August 2018 to ensure compliance with K920.<br>The Maintenance Director was in-serviced on the requirements noted on the 2567 on 5/28/18. | 5/28/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445516 | A. BUILDING 01 - MAIN BUILDING<br>B. WING | 05/14/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CREEKSIDE HEALTH AND REHABILITATION CENTER | 306 W DUE WEST AVE<br>MADISON, TN 37115 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 920 | Continued From page 5<br>following patient rooms:<br>a. Room 20<br>b. Room 5<br>NFPA 99, 10.2.4.2.2 (2012 Edition)<br><br>3. Observations on 05/14/2018 between 10:24 AM - 10:48 AM, revealed unapproved power strips in the following patient rooms:<br>a. Room 3 (multiple power strips)<br>b. Room 217<br>NFPA 99, 10.2.3.6 (2012 Edition)<br><br>The maintenance assistant was present when these deficiencies were identified, and were later acknowledged by the administrator during the exit conference on 05/14/2018. | K 920 | 4. The results of the weekly & monthly audits will be presented in the monthly Quality Assurance meeting to assure compliance with the requirements of K920. June – August 2018.<br>The Quality Assurance Performance Improvement Committee will include but not be limited to the following: Administrator, Medical Director, Director of Nursing, Unit Managers, Business Office Manager, Social Services Director, Dietary Manager, Housekeeping & Laundry Director, and Maintenance Director. | |